

California Network of Mental Health Clients

Response to

CA Department of Mental Health “Discussion Paper: Medi-Cal Reform, Potential Changes for Specialty Mental Health Services”

1. “Broadening sites where federal reimbursement for Medi-Cal services can be obtained, particularly “ freestanding psychiatric hospitals and psychiatric health facilities greater than 16 beds serving adults for inpatient services”

The California Network of Mental Health Clients (CNMHC) is very concerned about this proposal.

It would provide an incentive to hospitalize people. If beds are paid for by Medi-Cal, they will be filled. People will be diverted to hospitals, instead of community care; to forced treatment, instead of voluntary services. Services will follow the money.

Concerns:

- Why support hospitals that are over 16 beds? Large hospitals have proven, by their very nature, to institutionalize.
- Why not explore alternatives to hospitalization? Faced with the problem of not enough beds in some counties, why not explore other options to traditional hospitalization. Community crisis residential care, for example. When faced with a problem in resources for people in extreme emotional distress, why travel the old roads and answers, instead of creating alternatives in the community. It is a matter of changing the culture from thinking the same old institutional answers to thinking outside of the institution/hospital box.
- Why support for-profit psychiatric hospitals, which fit the designation of free standing hospitals and psychiatric health facilities? They have been notorious in their placement of self-interest over patient interest.
- Why provide the incentive to direct the flow of services away from the concept of Olmstead, community, self-directed care and recovery to the reopening of big hospitals and the institutionalization they represent.
- The Department of Mental Health’s proposed option is for acute, not long care, hospitalization. Would this stop with just acute hospitalization, or start the slippery slope toward the days of big institutional long term care? Also, how long is acute care?

Based on these concerns, the CNMHC is opposed to expanding Medi-Cal reimbursement for big psychiatric hospitals, acute or long term. Community services are less costly and more effective than hospitalization, as well as crucial to improving the quality of life for people with mental

disabilities. Providing incentives to hospitalize people would ultimately lead away- if not lead funds away – from services in the community.

2. “Add recovery oriented consumer operated peer support services for adults at risk of repeat hospitalization.”

There is growing pressure from clients and others for securing a federal or other secure funding stream for self-help and peer support programs.

The Report of the Consumer Issues Sub Committee to the President’s New Freedom Commission recommended:

“That peer support services be integrated into the continuum of community care and that public and private funding mechanisms be made sufficiently flexible to allow access to these effective support service.

The subcommittee proposes that a carve-out from the Federal Community Mental Health Block Grant funding be established to support the integration of community - based peer support services within the continuum of community care

We encourage the inclusion of billable peer services under the Medicaid Rehabilitation Option (as has been carried out in Georgia)” (www.mentalhealthcommission.gov)

The CNMHC has urged that maintaining and building self-help programs, which includes maintaining their integrity, should be a mental health policy priority. (“Self-Help and Peer Operated Services”, CNMHC Position Paper on Self-Help)

Two States, Colorado and Georgia have developed special waivers to fund self-help programs/peer support through Medi-cal.

However, there are many concerns about Medi-cal funding for self-help services. For example:

1. That the source of funding does not medicalize self-help services, i.e., the need for diagnosis, charting, etc.
2. That peers retain control of the services, “client-run” is maintained, instead of controlled by a licensed clinician(s) to authorize services.
3. That the paper work/accountability necessary for documentation would overwhelm and undermine the services of self-help programs.
4. That the option not be restricted to a specific group who use self-help services, in the case of the CDMH proposal to those who are “at risk of repeat hospitalization.”

The CNMHC community needs to discuss this option thoroughly.

Medi-Cal reimbursement of peer support services is a way of ensuring sustainability of self-help and peer support services, especially in the current climate of funding mechanisms that discourage self-help programs and severe budget shortages. On the other hand, this funding stream entails a high potential to undermine/compromise the very

essence of peer-run programs, what makes them successful and appealing to people who often won't use traditional services.

3. Consider a Cash and Counseling waiver (not proposed in the Department of Mental Health's "Discussion Paper.")

This option is not discussed in the Department of Mental Health's proposed Medi-care options. However, it deserves attention. It truly embodies self-directed care, in that the consumer has the money/vouchers and buys services from an approved list of services. The money follows the person.

"A recent Medicaid Cash and Counseling waiver program that focuses on people with physical disabilities, developmental disabilities/mental retardation, and older adults confirms ---- higher client satisfaction, increased numbers of needs being met, and equivalent levels of health and safety in a large population of people with disabilities." (Achieving the Promise: Transforming Mental Health Care in America, p. 35.) The President's New Freedom Commission Report recommends that mental health undertake a "similar demonstration waiver program to evaluate the potential benefits for people with mental illnesses." (p. 35.) In an unpublished paper, Judi Chamberlin and Dan Fisher of the National Empowerment Center report a similar "self-determination project" being implemented in Florida's mental health system, called, "the Florida Self-Directed Care program."

Looking at Medi-Cal Redesign in California as an opportunity for innovation that maximizes self-determination, this option deserves being studied.

Recommendations:

- **Convene a meeting of clients who are operating local self-help and peer support programs to have an in-depth discussion of Medi-Cal reimbursement of self-help programs, including exploring other avenues of bringing down federal dollars without having to bill services. The CDMH should listen to these experts/practitioners who are running self-help programs.**
- **If the CMHD then plans to proceed with this option, the CDMH should use peer consultants on the design and language of the option. The people directly involved with the operations of self-help and peer support programs who know the most about the operations of their respective programs should have maximum involvement with designing any Medi-Cal billing option.**